Rt Hon Norman Lamb MP, Minister of State for Care and Support

Speech to Reform conference, “Coordinated health and social care: what would it take to really make it happen?”

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[uncorrected]

Thank you very much indeed. It is a great pleasure to be here.

Reform has established itself over the years as an important and influential think tank. I am very pleased to have the chance to talk about the government’s approach to the challenges facing our health and care system.

For make no mistake, these challenges are huge.

People are living longer. The number of over-85s will more than double by 2030. This is of course a good thing. But they will not all be in rude health.

Indeed by 2018 nearly three million people will have three or more long-term conditions such as diabetes, arthritis or dementia.

And we have to deal with all this at a time of financial constraints. Even though we have maintained funding in real terms, health costs are expected to keep rising by 4% a year. Pressure on public finance will be a permanent feature; it won’t suddenly get easier.

The NHS has performed extremely well despite unprecedented financial constraints. In the last five years it has managed without large real terms increases in funding.

In fact the Commonwealth Fund rated it the most efficient health system in a study of the UK, USA, Australia, Canada, Germany, the Netherlands and New Zealand.

Yet NHS England projects that the NHS faces a funding gap of £30 billion by 2021. Plainly we have to marshal our resources ever more effectively.

The consequences of doing nothing would be disastrous. The NHS would crash.

So change is essential – not to undermine the NHS but in order to sustain it and to repair it.

I call these “the five shifts”.

The first concerns safety.

We have to be utterly obsessive in our focus on safe care, so that we have the best possible outcomes for patients. Payment should reward the quality of operations, not the number. This means encouraging experimentation in payment approaches using local variations and local price setting.

Best Price Tariffs encourage providers to deliver the best care and to reduce variation in the quality of care.
Last year I visited Intermountain Health, a not-for-profit integrated care organisation in Utah. They have shown that the rigorous pursuit of patient safety saves money. By designing a protocol that allowed them to spot sepsis cases and treat them quickly and simply, they managed to cut sepsis deaths of patients entering through their emergency department by over half.

Moreover, the average length of stay shortened by 20 hours and the average cost per patient fell by nearly $3,000.

This sort of approach can easily be replicated in the NHS.

The second is a shift from repair to prevention.

This will necessarily include changing the design of incentives – and that will include some trial and error. Happily there are leaders in this field. In Salford, the council, the clinical commissioning group, the acute and mental health foundation trusts, and local GPs have established an Alliance Model to support older people.

The contract is a mechanism that implements different payment regimes, where both the financial risks and benefits are shared. Risk is pooled across commissioners and providers, incentivising additional investment in services such as prevention, out of hospital care etc. This all shows that there is life after payment by results; it’s not the only model.

Meanwhile Leeds council is working with the NHS, charities and the private sector on technological approaches to better health.

They are looking at making it easier for patients to access the health service on their phone, new websites that help people manage long-term conditions, devices such as blood pressure monitors in people’s homes, and support for local businesses wanting to create patient-focused apps.

We can look to America for inspiration on apps.

Many diabetics have had to get used to self-administering blood sugar tests and insulin injections. Two Massachusetts doctors have developed an iPhone app which receives data every five minutes from a glucose monitor implanted in a patient’s body.

The app analyses the data, factors in the patient’s weight (which is a reliable proxy for blood volume) and transmits instructions to two implanted pumps.

One delivers insulin – to lower blood sugar – the other delivers glucagon – to raise it. The trial is looking very promising and the inventors are awaiting the blessing of the Food and Drug Administration.

This is a multi-million pound industry – and one that at which this country can be at the forefront.

The third shift is from being exclusive to inclusive.

Health and care cannot be the sole preserve of formal services. Let’s take loneliness, for example. Some five million people say that television is their main form of company.

This is appalling – all the more so because there is an established link between isolation and poor physical and mental health.
It’s about giving people better lives – happiness. And we all know that state can’t make people happy.

This is something which every one of us should take responsibility for.

The Cornwall and Isles of Scilly Pioneer and Friends and Neighbours in Sandwell.

The fourth shift is from paternalistic to personal.

I want people to have as much control as possible over their health and care, with services designed around them individually.

From October, people on the NHS Continuing Healthcare will have the right to a personal health budget. Those who have already experienced this memorably described it as the difference between existing and living.

The fifth shift is one that I am particularly passionate about: from fragmented to joined-up care.

Far too many people slip through the gaps between primary care, secondary care, mental health, and physical health. Let alone the gap between health and social care. But these distinctions do little to serve patients – who just want to know that they will get the care they need.

Fourteen Pioneers have been doing tremendously important work.

Barnsley has developed a centralised monitoring centre that is alerted to emergency cases. It assesses patients within one of three categories - individual, families, and communities - so they get the right help swiftly.

It could be daily support to help someone remain independent or dispatching a mobile response unit.

In Kent, clinical commissioning groups, the county council, district councils, acute services and the voluntary sector work together so that patients have access to 24/7 community-based care.

Patients will control their care record and have the option of a personal budget so they can choose the health and social care services they want.

South Devon and Torbay are providing mental health support in schools and putting more mental health workers in GP surgeries.

Acute hospital trusts are showing leadership as well.

Worcestershire Health and Care NHS Trust has an early intervention service for dementia in partnership with Dementia UK and the Alzheimer’s Society to offer a fully co-ordinated service. This pooling of expertise by the trust and the voluntary sector is inspirational.

Leeds and York Partnership NHS Foundation Trust are using “managed clinical networks” for mental health patients. These lever in a wide range of organisations and sectors such as housing and the criminal justice system. Predictably, this has led to much greater responsiveness all round.
The Greenwich Joint Emergency Team run by Oxleas NHS Foundation Trust is reducing unnecessary admissions to A&E and supports people leaving hospital. It is another multidisciplinary approach, one which responds within 24 hours.

Surveys have revealed extremely high levels of satisfaction and that 31 per cent of patients would have gone to A&E if the Joint Emergency Team had not intervened.

We have recently announced a further investment of £90,000 for each of the pioneers. This will be money well spent, as they are providing a scalable model of how we can achieve much greater integration across the system.

And the Better Care Fund is going to amount to some £5.2 billion rather than the £3.8 billion we initially envisioned. It is there to encourage organisations to act earlier to prevent people reaching crisis point, to make seven-day services a reality, and to deliver care that is centred on people’s needs.

Ultimately, I want to see the whole of the health and care budget pooled.

But how do we ensure that these shifts happen? Well, we have tested to destruction the top-down model where change is dictated from Whitehall. It doesn’t work.

The 1.3 million people who work in our NHS raise their eyes heavenwards as they prepare for more imposed disruption.

Instead, I believe in a more personal NHS. It must be less risk adverse. It has to innovate, so let’s encourage local leaders across the country to try new approaches to achieve better care and a sustainable NHS.

So, with an aging population and major financial pressures, the stakes are really high. But so are the rewards. The NHS remains one of this country’s greatest success stories. By adapting to the new reality, it can not only survive but thrive.

Thank you, and I look forward to your questions.